IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

August 13, 2010

Russell McCoy, Administrator
South Bannock Group Home
415 South Arthur
Pocatello, ID 83204-3317

RE: South Bannock Group Home, Provider #13G015

Dear Mr. McCoy:

This is to advise you of the findings of the Medicaid/Licensure survey of South Bannock Group Home, which was conducted on July 30, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner**:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or

other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **August 24, 2010**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informational Letter #2007-02. State Informational Letter #2007-02 can also be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/ICFMR/tabid/431/Default.aspx

This request must be received by August 24, 2010. If a request for informal dispute resolution is received after August 24, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MONICA NIELSEN
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MN/srp
Enclosures

DEVELOPMENTAL OPTIONS
PROMOTING FUNCTIONAL INDEPENDENCE THROUGH PERSON-CENTERED SERVICES

August 25, 2010

Ms. Nicole Wisenor, Supervisor
Non-Long Term Care
Department of Health and Welfare
Division of Medicaid
Bureau of Facility Standards
P. O. Box 83720
Boise, ID 83720-0036

Dear Nicole:

Please find enclosed the completed *STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION* for South Bannock Group Home from the survey completed July 30, 2010. On the Statement of Deficiencies / Plan of Correction, Form HCFA-2567, I have listed the necessary corrective actions.

I hope you find the Statement of Deficiencies / Plan of Correction acceptable. If there is any additional information you require or if you have any questions, please contact me at the address listed above.

Sincerely,

Russell C. McCoy, M.A. Ed.
Executive Director

Enclosures

Russell C. McCoy, Executive Director • rmccoy@ida.net

415 South Arthur • Pocatello, Idaho 83204 • Phone (208) 233-6833 • Fax (208) 233-6842 • doptions@ida.net • www.developmentaloptions.com

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G015	A. BUILDING _____ B. WING _____	07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH BANNOCK GROUP HOME	3875 SOUTH BANNOCK HIGHWAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Monica Nielsen, QMRP, Team Leader Michael Case, LSW, QMRP Common abbreviations/symbols used in this report are: IPP - Individual Program Plan LPN - Licensed Practical Nurse PTSD - Post Traumatic Stress Disorder QMRP - Qualified Mental Retardation Professional SIR - Significant Incident Report	W 000	RECEIVED AUG 27 2010 FACILITY STANDARDS	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure accurate information was provided to parents/guardians on which to base consent decisions for 1 of 4 individuals (Individual # 1) whose consents were reviewed. This resulted in an individual's parent/guardian not receiving accurate information necessary to make informed treatment decisions. The findings include:	W 124	**W 124 480.420(a)(2)** For Individual #1 the facility will revise the Consent to treat. The Qualified Mental Retardation Professional will review the other individuals' Consent to treat documents to ensure accuracy. The consent to treat documents will be reviewed on a bi-annual basis for accuracy by Qualified Mental Retardation Professional. Corrective Action Completion Date: September 30, 2010 Person Responsible: Jamie L. Anthony, Residential Program Director	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	08/24/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 124	Continued From page 1 1. Individual #1's IPP, dated 10/27/09, documented a 40 year old male diagnosed with profound mental retardation and Ring 22 (a chromosome disorder). According to his historical records, he was also diagnosed with PTSD and depression. Individual #1's medical record showed he was diagnosed with neurofibromatosis (a genetically-inherited disorder in which the nerve tissue grows tumors) in 3/07. According to his record, his health continued to decline and he began receiving hospice services on 7/15/09. Additionally, his Nutritional Assessment, dated 3/10/10, showed his diet was changed from mechanical soft to puree due to his decreased ability to chew. During an observation on 7/26/10 from 5:50 - 6:45 p.m., Individual #1's food was noted to be pureed and a staff was noted to be feeding him. When asked, present staff stated Individual #1's diet was pureed and he was unable to feed himself due to his declining health. However, Individual #1's Consent to Treat, dated 4/28/10, stated he received Celexa (an antidepressant drug) 10 mg a day to treat the symptoms of PTSD and depression. According to the Consent, the symptoms included crying, yelling, and aggression. The Consent stated he attended counseling sessions to assist him with coping with PTSD and depression and plans were in place to address the symptoms. Individual #1's record showed he was receiving Celexa but there were no plans to address crying, yelling, and aggression.	W 124		

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W 124	Continued From page 2 When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., Individual #1 did not exhibit yelling and aggression anymore and did not attend counseling due to the decline in his health. The QMRP stated the Consent was not accurate and needed to be revised. The facility failed to ensure the information in Individual #1's Consent to Treat was accurate.	W 124		
W 218	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure the sensorimotor assessments were updated as needed for 1 of 4 individuals (Individual #1) whose sensorimotor assessments were reviewed. This resulted in an individual's occupational therapy assessment not being an accurate reflection of his current health status. The findings include: 1. Individual #1's IPP, dated 10/27/09, documented a 40 year old male diagnosed with profound mental retardation and Ring 22 (a chromosome disorder). Individual #1's medical record showed he was diagnosed with neurofibromatosis (a genetically-inherited disorder in which the nerve tissue grows tumors) in 3/07. According to his record, his health continued to decline and he began receiving hospice services	W 218	**W 218 483.440(c)(3)(v)** For individual #1 the facility will have an updated Occupational Therapy assessment completed. The Qualified Mental Retardation Professional will review the other individuals' charts to see if an updated occupational therapy assessment is required. The need for occupational therapy assessments will be evaluated on an 'as needed basis' if the client exhibits significant declines or at the IPP meeting. Corrective Action Completion Date: September 30, 2010 Person Responsible: Jamie L. Anthony, Residential Program Director and Christy Day, Lead LPN	

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W 218	Continued From page 3 on 7/15/09. Individual #1's Occupational Therapy Evaluation, dated 7/20/09, recommended an angled spoon and universal cuff to assist him with eating. However, during an observation on 7/26/10 from 5:50 - 6:45 p.m., staff were noted to feed him his evening meal. When asked, present staff stated Individual #1 was unable to feed himself anymore due to his declining health. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., an updated occupational therapy evaluation had not been completed. The facility failed to ensure Individual #1's occupational therapy evaluation was revised to reflect his current needs.	W 218		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of an individual's IPP that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 1 of 2 individuals (Individual #1) whose behavior	W 312	**W 312 483.450(e)(2)** For individual #1, a medication reduction plan will be implemented. The Qualified Mental Retardation Professional will review the other individuals' charts to ensure adequate medication plans are in place. The medication plans will be reviewed for accuracy each time a medication is modified or during the IPP meeting if no changes have been made. Corrective Action Completion Date: September 30, 2010 Person Responsible: Jamie L. Anthony, Residential Program Director	

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W 312	Continued From page 4 modifying drugs were reviewed. This resulted in an individual receiving behavior modifying drugs without plans that identified the drugs usage and how they may change in relation to progress or regression. The findings include: 1. Individual #1's IPP, dated 10/27/09, documented a 40 year old male diagnosed with profound mental retardation and Ring 22 (a chromosome disorder). According to his historical records, he was also diagnosed with PTSD and depression. Individual #1's medical record showed he was diagnosed with neurofibromatosis (a genetically-inherited disorder in which the nerve tissue grows tumors) in 3/07. According to his record, his health continued to decline and he began receiving hospice services on 7/15/09. Individual #1's Consent to Treat, dated 4/28/10, stated he received Celexa (an antidepressant drug) 10 mg a day to treat the symptoms of PTSD and depression. According to the Consent, the symptoms included crying, yelling, and aggression. The Consent stated he attended counseling sessions to assist him with coping with PTSD and depression and plans were in place to address the symptoms. Individual #1's record showed he was receiving Celexa but there were no plans related to the use of Celexa or to address crying, yelling, and aggression. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m.,	W 312		

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W 312	Continued From page 5 Individual #1 did not exhibit yelling and aggression anymore and did not attend counseling. The QMRP stated with Individual #1's decline in health, the only behavior they witnessed from him was crying. When asked, the QMRP stated they had no plan related to crying as they started tracking it on 6/18/10. The facility failed to ensure plans were in place to address the use of Celexa for Individual #1.	W 312		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure appropriate preventative medical care was provided for 1 of 4 individuals (Individual #2) whose medical record was reviewed. This resulted in an individual sustaining injuries due to falls with no prevention plan in place. The findings include: 1. Individual #2's IPP, dated 9/15/09, documented a 49 year old male diagnosed with profound mental retardation, diabetes mellitus, and seizure disorder. An SIR, dated 3/25/10 at 10:10 a.m., showed Individual #2 was standing against a wall then suddenly fell over and hit his face on the door frame. In the process, he hit his mouth and knocked out one of his front teeth. He was taken to the dentist and the tooth was re-attached.	W 322	**W 322 483.460(a)(3)** For Individual #2, a fall prevention plan will be implemented. The facility will create a fall assessment which will help direct the need for any additional fall prevention plans. This will be added to the annual IPP assessments completed each year on all of residents. Corrective Action Completion Date: September 30, 2010 Person Responsible: Jamie L. Anthony, Residential Program Director	

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W 322	Continued From page 6 A second SIR, dated 3/31/10 at 10:30 (time not indicated), showed Individual #2 was leaning against a wall. He shuffled his feet and fell over sideways. He hit his mouth on the arm of another individual who was standing nearby and his front tooth was knocked loose. According to the SIR, Individual #2 was "put on stand by assistance until further notice." Individual #2's historical record contained a 2009 Fall Log which showed that on average, he was experiencing 2.5 falls a month. When asked, the LPN stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., Individual #2 did not have a fall prevention plan. The facility failed to ensure a fall prevention plan was developed for Individual #2.	W 322		
W 455	483.470(I)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases. That failure directly impacted 1 of 1 individual (Individual #5) observed eating lunch at a local park, and had the potential to impact all individuals (Individuals #1 - #8) residing in the facility. This had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include:	W 455	**W 455 483.470(I)(1)** The facility will purchase and make available table cloths for picnic use. A quality assurance form will be created addressing infection control examples. Corrective Action Completion Date: September 30, 2010 Person Responsible: Jamie L. Anthony, Residential Program Director	

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W 455	Continued From page 7 1. During an observation on 7/27/10 from 12:25 - 1:00 p.m., Individual #5 was noted to be sitting at a picnic table in a local park. The picnic table was noted to contain bird droppings. Individual #5 was observed eating his yogurt with a spoon. It was noted that after each bite of yogurt, he placed his spoon on the picnic table. Present staff was asked about the cleanliness of the table. The staff proceeded to use her already-used napkin, pick up Individual #5's spoon and wipe it off with her napkin. The staff handed the spoon to Individual #5 who proceeded to eat his yogurt. When asked, the LPN and QMRP both stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., Individual #5 should have been provided with a place-mat and a clean spoon. Repeat Deficiency	W 455		

Bureau of Facility Standards

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MM164	16.03.11.075.04 Development of Plan of Care To Participate in the Development of Plan of Care. The resident must have the opportunity to participate in his plan of care. Residents must be advised of alternative courses or care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives must be elicited and considered in deciding on the plan of care. A resident may request, and must be entitled to, representation and assistance by any consenting person of his choice in the planning of his care and treatment. This Rule is not met as evidenced by: Refer to W124.	MM164	**MM164 16.03.11.075.04** Refer to W124 RECEIVED AUG 27 2010 FACILITY STANDARDS	
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	MM197	**MM197 16.03.11.075.10(d)** Refer to W312	
MM724	16.03.11.270.01(a) Assesments As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W218.	MM724	**MM724 16.03.11.270.01(a)** Please refer to W218	
MM735	16.03.11.270.02 Health Services	MM735	**MM735 16.03.11.270.02**	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 08/24/10

Bureau of Facility Standards

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MM735	Continued From page 1 The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735	Please refer to W322	
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769	**MM769 16.03.11.270.03(c)(vi)** Refer to W455	